REFERRAL AND AUTHORIZATION FOR CSHCS DIAGNOSTIC EVALUATION Instructions

PURPOSE:

Children's Special Health Care Services (CSHCS) covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition, but the appropriate information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, **NOT FOR PROVIDING TREATMENT**. The Local Health Department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. The client may not have an I.D. Number at the time of the appointment.

LOCAL HEALTH DEPARTMENT INSTRUCTION:

- Complete the form and give two copies to the client.
- Send a copy to MDCH - CSHCS Customer Support via fax (517) 335-9491 or mail:

  CHILDREN'S SPECIAL HEALTH CARE SERVICES DIVISION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30734
  LANSING, MI 48909-8234

- Retain a copy for your file.
- Additional visits may occur as a result of the initial authorized visit for completion of the diagnostic evaluation.
- Additional visits MUST be for the same referral/diagnosis reasons listed on the "initial" authorization.

CLIENT INSTRUCTIONS

- Give one copy of this "Diagnostic Referral" to the authorized provider in order for the provider to bill for this service.
- You must also show your copy of this form to all other providers who are providing services related to this diagnostic referral (lab., x-ray, etc.).
- Keep a copy for your records.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

AUTHORITY: Title V of the Social Security Act.
COMPLETION: Is voluntary, but is required if CSHCS payment is desired.

PROVIDER INSTRUCTION:

- You must attach a **photocopy** of this "Diagnostic Referral" form to your invoice when submitting a bill to the Michigan Department of Community Health for CSHCS services.
- All invoices must be Medicaid acceptable.
- Enter the word "**diagnostic**" in the Remarks section of the invoice.
- If the client has **private health insurance**, you must bill that insurance company **first**. Also, attach a copy of the Explanation of Benefits (EOB) to your invoice.
- As an enrolled provider, you have agreed to accept the Medicaid/CSHCS payment (plus private insurance payments where applicable) as payment in full.
- All claims must be submitted within **12 months** of the date of the service. Failure to do so will result in the denial of payment.
- Send claims to:

  MANUAL PAYMENTS UNIT
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30688
  LANSING, MI 48909

- Send a copy of the **medical report** to:

  CHILDREN'S SPECIAL HEALTH CARE SERVICES DIVISION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30734
  LANSING, MI 48909-8234

Michigan Department of Community Health
Children's Special Health Care Services Division

REFERRAL AND AUTHORIZATION FOR CSHCS DIAGNOSTIC EVALUATION

Appointment Date	Time	Evaluation Type	Procedure Request	
		☐ First (initial)	☐ Laboratory	☐ Other
		☐ Follow-up	☐ Radiology	

IMPORTANT:

- **Additional visits may occur as a result of the initial authorized visit for completion of the diagnostic evaluation.**
- **Additional visits MUST be for the same referral/diagnosis reasons listed on the "initial" authorization.**

CSHCS AUTHORIZED PROVIDER INFORMATION

Name of Provider	Provider Phone Number ( ) -		
Provider Address	City	State	Zip Code

CLIENT INFORMATION

Name of Client (Last, First, Middle)	Date of Birth	Gender ☐ M ☐ F	Social Security Number - -
Client Address	City	State MI	Zip Code
Health Insurance Company Name	Policy Number	Client County of Residence	
Policyholder Name	Relationship to Client	Family Phone Number ( ) -	

TYPE OF EVALUATION/REASON(S) FOR REFERRAL or FOLLOW-UP

List the Reason(s) (i.e. history, signs and symptoms of suspected condition, etc.)

PARENT/LEGALLY RESPONSIBLE PARTY RELEASE OF INFORMATION AUTHORIZATION

- I am responsible for this child/client and I agree to this diagnostic evaluation.
- I agree to the release of ALL medical information resulting from the evaluation to the MDCH, CSHCS Division.
- I know that this information may include information about any of the following:
  - Human Immune Deficiency Virus positivity (HIV+)
  - Acquired Immune Deficiency Syndrome (AIDS)
  - AIDS Related Complex (ARC) as defined by the Michigan Department of Community Health

Parent/Legally Responsible Party Name (Print)	Parent/Responsible Party Phone Number ( ) -
Parent/Legally Responsible Party Signature	Date Signed

FOR LOCAL HEALTH DEPARTMENT USE ONLY

Referred By	Agency Name	County
LHD Authorizing Signature	Date Signed	Agency Phone Number ( ) –

COPY DISTRIBUTION: ORIGINAL - Client/Provider
COPY 1 - Client
COPY 2 - CSCHCS/CSS
COPY 3 - LHD